Tomah Health Job Shadow Application and Agreement Information

Welcome! To ensure that you get maximum benefit from your Job Shadowing experience, there are several topics we think you should know about.

CONFIDENTIALITY: The nature of the health care industry and the state and federal privacy laws require all job shadows to maintain a high level of confidentiality. All medical and business information is confidential. **Under no circumstances will such information be discussed with any unauthorized person(s) either outside or inside of the health care facility**. To engage in discussions of confidential information is a breach of privacy and may lead to legal consequences.

INFECTION PREVENTION: Proper hand washing helps to prevent the spread of infections from one person to another. Hand washing products are available in the restrooms and work areas.

You may not enter any room designated "Isolation". If there is a potential that you will have direct contact with a patient's blood or other body fluids, you **must** wear personal protective equipment

GENERAL SAFETY: The overhead paging system will announce safety alerts. Stay with your designated preceptor for more instruction.

SMOKING: Tomah Health is a tobacco-free healthcare facility.

DRESS CODE: You will be instructed on the appropriate work attire for your requested job shadow area.

HEALTH REQUIREMENTS: All health requirements, as listed on the application, must be completed before job shadowing. This includes TB screening, two dates of MMR, Varicella immune status by titer or 2 vaccines, and Influenza Vaccination information if shadowing between October 1st – March 31st. Please note, applicant must have a flu vaccine on file with Tomah Health to shadow during flu season. Declinations will not be accepted.

MISCELLANEOUS INFORMATION: If you are unable to report for your scheduled job shadow experience, please notify the assigned department manager or the HR department.

The Job Shadow Agreement must be signed.

Tomah Health
JOB SHADOW APPLICATION

Please turn in this completed form, along with the signed Job Shadow Agreement at least two weeks prior to your requested Job Shadow date.

Name: _____ School: _____

Address: _____ Grade: _____

City: _____ School Contact: _____

Phone Number: _____ Today's Date: _____

Age: _____ DOB: _____

Email address: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Preferred days to take part in a job shadow experience. Select all that apply or list dates:
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday @ Times: _____

Department(s) Requested: _____ or

Career Interest or unit: _____

Name of person you would like to shadow (if known): _____

Job Shadow Application Health Screening: **PERSONAL HEALTH HISTORY**

1. Do you have any major medical problems that we should be aware of? Yes No If yes explain,

_____

_____

_____

Immunizations (must attach copies of all immunizations)
Hepatitis B x3 vaccine dates *or* titer date:
Influenza vaccine date (Required if Shadowing Oct 1st – March 31st):
Measles, Mumps, & Rubella (MMR) x2 vaccine dates or titer date:
Tetanus, Diphtheria and Pertussis (Tdap) vaccine date:
Tuberculosis skin test or blood draw date (2 step or blood draw required for those shadowing over 40 hours):
Varicella x2 vaccine dates or titer date:

I certify the health history requirements are true and complete.

Signature: _____ Date: _____

Tomah Health
TB Risk Assessment

Name:	Date:	Phone Number:

1. Have you ever had a positive TB test?	[ ] Yes	[ ] No	When?
Were you given medication for it?	[ ] Yes	[ ] No	What?
2. Have you traveled overseas within the past two years or born out of country?	[ ] Yes	[ ] No	Where?
3. Have you ever had active TB or exposed to someone with infectious TB?	[ ] Yes	[ ] No	When Meds?
4. Have you ever had BCG vaccine? (Tuberculosis Vaccination)	[ ] Yes	[ ] No	When? Where?
5. Have you ever been told by a health practitioner that your immune system is suppressed or compromised?	[ ] Yes	[ ] No	
6. Have you received a MMR (Measles/Mumps /Rubella), Chicken Pox, or Shingles vaccination in the past 6 weeks?	[ ] Yes	[ ] No	If yes, date(s) of vaccine given:
7. In the last year, have you had:			If yes to any please explain:
Chronic Fatigue?	[ ] Yes	[ ] No	
	[ ] Yes	[ ] No	
Persistent cough-lasting more than 3 weeks?	[ ] Yes	[ ] No	
	[ ] Yes	[ ] No	
Unexplained weight loss?	[ ] Yes	[ ] No	
	[ ] Yes	[ ] No	
Known exposure to TB?	[ ] Yes		

Unexplained fever? Night sweats? Coughing up blood?			
8. Were you an employee at a correctional facility, long term care facility or a shelter for the homeless in Alaska, California, Florida, Hawaii, New Jersey, New York, Texas or Washington DC?	[ ] Yes	[ ] No	If yes to any please explain:
Applicant / Patient Signature:	Date:		
Reviewed by:	Date:		

JOB SHADOW APPLICATION (continued)

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Health history reviewed by:_____ Date:_____

Mentor:_____

Mentor scheduled for date / time:_____

Thank you for taking the time to complete this application. We are eager to introduce you to rewarding careers in rural healthcare! We will review your application and do our best to match you with an appropriate mentor. All sections of this application must be completed prior to your job-shadowing experience. Please return this application to:

Human Resources
Tomah Health
501 Gopher Drive, Tomah, WI 54660
PH: (608) 377-8614
FAX: (608) 377-8729

PLEASE READ THIS SECTION CAREFULLY BEFORE SIGNING

(If a minor, a parent or legal guardian's signature is mandatory)

Job Shadow Agreement

1. I, have requested to be present in the hospital, clinic, or hospice.

   I, the Job Shadow Participant, agree to adhere to the following rules:

   a. Read Tomah Health's job shadow application and agreement information and adhere to the information I will ask questions if I do not understand the information.
   b. Follow good hand-washing techniques
   c. Adhere to the job shadow dress code
   d. Wear personal protective equipment if there is a potential of contacting blood or other body fluids
   e. Wear a name tag identifying myself as a Job Shadow
   f. Inform my mentor if at any time I feel ill during the shadowing activity
   g. Arrive promptly and remain flexible to allow for extenuating circumstances such as patient emergencies that might interrupt the schedule
   h. Remain at all times where directed and leave the areas when requested to do so by a physician, nurse, or administration
   i. At the conclusion of my assignment, complete an evaluation of the program and return to HR.

2. I understand the patient's right to confidentiality and agree to respect that right by not disclosing information regarding any patient or regarding the organization/administration.

3. I understand this permission may be revoked at any time during the observation period by the attending physician or other staff.

4. In consideration of the permission granted, I hereby release the physicians, the organization, and its employees from any claims or liability, physical injury and/or damage including emotional distress or injury or mental anguish which may be sustained by me as a result of the presence of myself in the hospital, clinic, or hospice setting.

5. I am age 15-17 years of age with parental/guardian consent or am over the age of 18

SIGNED BY:

_____ _____

Signature of Participant Date

_____

Printed Name

_____ _____

Signature of Parent/Guardian of Minor *(required if under 18)* Date

_____

Printed Name